TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Methodist Hospital for Surgery

Respondent Name
Liberty Insurance Corp

MFDR Tracking Number
M4-17-1017-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
December 9, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Because Liberty Mutual failed to reprocess the Hospital's claim following its submission of a corrected bill with request for separate implant reimbursement, and because Liberty Mutual, by its EOPs of June 6, 2016 and July 12, 2016, misrepresented the nature of the dispute, the Hospital urges that its delay in filing a request for MFDR is subject to the exception of timely filing of such a request found in 133.307(c)(B)."

Amount in Dispute: $23,015.26

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This bill has been re-reviewed for dates of service 11/04/2015-11/07/2015. The provider did not request separate reimbursement on original submission of the bill (attached). DRG 460 was priced @143% of CMS' IPPS rate at time of original review for a total allowance of $32,980.09."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 4 – 7, 2015	Inpatient Hospital Services	$23,015.26	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes: December 7, 2015
   - X079 – Please submit one or more of the following records which pertain to your bill: Operative report, discharge summary, itemized bill, anesthesia records, medical report.

April 4, 2016

- Z710 – The charge for this procedure exceeds the fee schedule allowance
- P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
- W3 – Additional payment made on appeal/reconsideration
- U634 – Procedure code not separately payable under Medicare and or fee schedule guidelines
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

May 27, 2016

- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment
- Z710 – The charge for this procedure exceeds the fee schedule allowance
- P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
- W3 – Additional payment made on appeal/reconsideration
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- U634 – Procedure code not separately payable under Medicare and or fee schedule guidelines

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states:

> Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.
>
> (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

The date of the services in dispute is November 4 – 7, 2015. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on December 9, 2016. This date is later than one year after the date(s) of service in dispute.

28 Texas Administrative Code §133.307(c)(1)(B) states,

> (B) A request may be filed later than one year after the date(s) of service if:
>
> (i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability;
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> (ii) a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requestor received the final decision on medical necessity, inclusive of all appeals, related to the health care in dispute and for which the insurance carrier previously denied payment based on medical necessity; or
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> (iii) the dispute relates to a refund notice issued pursuant to a division audit or review, the medical fee dispute must be filed not later than 60 days after the date of the receipt of a refund notice.

Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B).

The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		December 28, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.